

## **The Honorable Tim Murphy**

1. **Patients and health providers have their advocates. What about the families of the mentally ill? What about people like Joe Bruce?**
  - a. **In your book, *Out of the Shadows*, you discuss the different ways of ensuring accountability for and measuring the performance of mental health services. You give the example of the Riverside County Department of Mental Health in California that employs a full-time Family Advocate whose job is to solicit information from families about problems in the county mental health treatment system. As far as you know, has the practice expanded since your book came out? Would it help? Why or why not?**

I described the Riverside County family advocate program as it existed in the mid-1990s. At that time, the county had an excellent Director of Mental Health who was very interested in improving the county's services for individuals with serious mental illnesses. The family advocate program has continued in Riverside County and has spread to approximately six other counties in California. However, its usefulness depends largely on the interests of the county Director of Mental Health. In Riverside County, for example, the person who replaced the man who started the program has had less interest in using the information.

Do such programs help to improve services? They certainly can do so by providing ongoing input from patients and families to county officials regarding what is and is not working and weaknesses in their programs. This assumes, of course, that the county officials want such information, which is currently not true except in unusual instances. County officials will want such information only if they are being evaluated on how well they are doing their job and are being held responsible for patient outcomes. Presently, because of the thought-disordered way we are funding mental illness services, county officials are largely judged on a single criteria, and that is how successful they are in shifting the cost of services from the county and state to federal sources, especially Medicaid and Medicare. If the primary funding for mental illness services was shifted from the federal government back to the states, as existed prior to 1963 when the federal Community Mental Health Centers Act was passed, and the states were held fully responsible for mental illness services, then the use of family advocates would become widespread.

- b. **Is SAMHSA presently funding programs that promote the spread of Family Advocates? Should they be?**

SAMHSA has funded, and currently is funding as far as I know, Mental Health America (MHA) and NAMI, the two largest associations of family advocates. I do not believe that SAMHSA or any other government agency, federal or state, should be funding such advocacy groups, since it renders them completely ineffective as advocates. For family or patient mental illness advocacy groups to be effective, they must be able to publicly

criticize government agencies which are failing to do an adequate job on services and/or research. Without this ability such advocacy groups are effectively emasculated, and operate merely with the appearance of being an advocacy group but without any ability to do so.

Government agencies, of course, know this and that is why they fund the advocacy groups. Thus when SAMHSA was recently being criticized, Mental Health America publicly sprang to SAMHSA's defense and suddenly decided to give SAMHSA Administrator Pamela Hyde a public award. Similarly, the majority of state NAMI offices now receive the majority of their funding from the state departments of mental health (e.g., in New York State it is 92 percent), and are thus unable to criticize the departments. As state mental illness services have deteriorated progressively over the past two decades, it is remarkable how quiet most state and national NAMI and MHA groups have been. For advocacy groups to be effective, they must be completely financially independent from the government agencies which are the objects of their advocacy. This is why the Treatment Advocacy Center, which I founded, has never accepted any funds from government agencies or from pharmaceutical companies.

**The Honorable Paul Tonko**

- 1. Dr. Torrey, you have been an outspoken critic of SAMHSA for quite some time and have repeatedly called for its abolishment. You acknowledge, however, that some programs at SAMHSA have merit and value. In your opinion, what are the “good programs” at SAMHSA that you would like to keep and potentially expand?**

I have indeed called for the abolishment of SAMHSA for more than a decade but have never said that SAMHSA did not have some programs of merit and value. Such programs would be much more valuable, however, if transferred to other agencies, such as was proposed by Senator Tom Coburn in his analysis of SAMHSA in his 2011 report, “Back in Black.” Examples of SAMHSA programs which I believe have some merit include:

- The data collection branch: This branch has competent staff but is badly underutilized because they are not asked to collect the most relevant data. For example, they collect data on the decreasing number of public psychiatric beds available but do not collect data on the logical corollary: where do such patients go if the beds are no longer available? The answer is to jails, prisons, and the streets.
- Integrated “wraparound” services for adolescents with mental illness and substance abuse disorders: Some of these programs are excellent. However, SAMHSA should fund such programs as demonstration projects, not permanent funding. They should carefully evaluate what works and what does not work, and demonstrate how these programs ultimately save money.
- Programs for homeless individuals with serious mental illness: Some of these programs have been very useful. Like the “wraparound” services, however, they should be funded as demonstration programs with careful cost-benefit evaluations, not as permanent federal funding as is now the case. Another shortcoming of this program is SAMHSA’s requirement that the mentally ill homeless persons being served by the program must agree to the services. This assumes that the mentally ill individual is aware of their own illness and need for treatment. I personally volunteered for 16 years in free clinics for homeless individuals in Washington, D.C. and can testify that no more than one-quarter of homeless mentally ill individuals are aware of their illness and need for treatment. The other three-quarters have a lack of awareness of their illness caused by damage to the brain by their mental illness, a condition we call anosognosia. Thus this SAMHSA program, which is one of the agency’s best programs, is ineffective for three-quarters of its target population.
- Mental Health Block Grant: In theory, this should be one of SAMHSA’s best programs and in fact it does some good, not because of SAMHSA but despite SAMHSA. The purpose of these Block Grants, as described in federal statutes (section 300, formula grants to states, under Title 42, The Public Health and Welfare) is to improve “community mental health services to individuals who are either adults with a serious

mental illness or children with a serious emotional disturbance.” The target population for these Block Grants is thus clearly prescribed by law. However, SAMHSA has its own priorities for the mental health Block Grants, as detailed on its website: “SAMHSA strongly recommends that Block Grant funds be directed...to fund...prevention activities and services for individuals not identified as needing treatment.” Since we have no knowledge of how to prevent serious mental illnesses, to order the funds for this program to be used for prevention and for individuals “not identified as needing treatment” is absurd and probably illegal.

- Specifically regarding your Congressional district (21<sup>st</sup> New York) I would like to point out one other important shortcoming of SAMHSA. In 1977, a study was done in Albany County in which the number of homicides committed by mentally ill individuals for the period before wholesale discharges from psychiatric hospitals (1963-69) was compared with the number of homicides after discharges were underway (1970-75). Although the number of homicides by non-mentally ill individuals did not change between the two periods, the number of homicides by seriously mentally ill individuals increased from one (an eighty-two-year-old man with dementia) to eight, all of whom were diagnosed with schizophrenia. These eight individuals were responsible for 29 percent of all homicides in the county during the six-year period. The authors of the study recommended that additional studies be done and concluded that “closer follow-ups of psychotic patients, especially schizophrenics, could do a lot to improve the welfare of the patient and the community.”<sup>i</sup> Such additional studies, which should have been done by SAMHSA, were never done and “closer follow-ups of psychotic patients” never took place. That is why your Congressional district and every other Congressional district, has continued to see a *minimum* of 10 percent of all homicides committed by seriously mentally ill individuals who are not being treated. This issue has been completely ignored by SAMHSA.

Please let me know if you have additional questions.

E. Fuller Torrey MD  
Founder, Treatment Advocacy Center

---

<sup>i</sup> F. Grunberg, B.I. Klinger, and B. Grumet, “Homicide and deinstitutionalization of the mentally ill,” *American Journal of Psychiatry* 134 (1977): 685-87; F. Grunberg, B. I. Klinger, and B. R. Grumet, “Homicide and community-based psychiatry,” *Journal of Nervous and Mental Disease* 166 (1978): 868-74.